Ortho1
April 2007

Department of Public Health and Human Services

Medicaid/Special Health Services OrthodontiaTreatment Plan

Name:	Provider Name: Tax ID #:
DOB:	NPI #
Address:	Address
Phone:	Phone: FAX:
Health Insurance: Number:	Signature:

For Category A *complete the following information, include appropriate Phase of Treatment and submit to SHS, 1400 Broadway, POB 202951, RmC-314, Helena, MT, 59620 or FAX to SHS at 406-444-2606. For questions, contact SHS at 406-444-3622. See reverse for Phase of Treatment information. Please submit additional comments separately.* ***For Category B,*** *complete the following information, include Phase 0 information and submit to Consultec POB 8000, Helena, MT, 59620; Include x-rays, molds, and or photographs.*

Molar Relationship

Class I ☐

Class II ☐

Class III ☐

Class III Facial ☐

Habits

Tongue Thrust Swallow ☐ Thumb/finger ☐

Large Tonsils/Adenoids ☐ Muscle Strain ☐

Clenching Teeth/Grinding ☐ Mouth Breathing ☐

Oral Hygiene

Excellent ☐ No plaque present

Good ☐ Plaque present on some tooth surfaces

Fair ☐ Plaque present & covering < ½ of all tooth surfaces

Poor ☐ Plaque present & covering >½ of all tooth surfaces

Areas of Concern: Crossbite ☐ Missing Teeth ☐ Impaction ☐ Frenum Abnormality ☐

Cleft Lip &/or Palate ☐ Gum Defects ☐ Extra Teeth ☐ Craniofacial Anomaly ☐

_____

DPHHS Authorization

PHASE 0 Interceptive Orthodontia for Medicaid recipients only; Category B

Appliances: Hyrax ☐ Quad Helix ☐ Hass ☐

Reverse Headgear/Face mask ☐

Retainers ☐ Other ☐ _____

_____

Category A

TREATMENT RECOMMENDATIONS

DENTAL DEVELOPMENT

ABCDE|FGH I J
TSRQP|ONMLK

8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8

Over for Phase I through IV

Treatment Goal: Crossbite Correction

Anterior x-bite ☐ Posterior x-bite ☐

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE I Early Expansion with Retention

Appliances: Hyrax ☐ Quad Helix ☐ Hass ☐

Reverse Headgear/Face mask ☐

Retainers ☐ Other ☐ _____

_____

TREATMENT RECOMMENDATIONS

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8

Exposure At:

_____

Treatment Goal: Maxillary Expansion

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE II Partial Banding with Retention

Appliances: Hyrax ☐ Quad Helix ☐ Hass ☐

Reverse Headgear/Face mask ☐

Retainers ☐ Other ☐ _____

_____

TREATMENT RECOMMENDATIONS

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8

Exposure At:

_____

Treatment Goal: Maxillary Development; Dental alignment with mixed dentition

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE III Banding with Retention

Appliances: Hyrax ☐ Quad Helix ☐ Hass ☐

Reverse Headgear/Face mask ☐

Retainers ☐ Other ☐ _____

_____

TREATMENT RECOMMENDATIONS

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8

Exposure At:

_____

Treatment Goal: Maxillary Development; Alignment of Permanent Dentition; Retention

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE IV Presurgical, Surgery, & Retention

Appliances: Hyrax ☐ Quad Helix ☐ Hass ☐

Reverse Headgear/Face mask ☐

Retainers ☐ Other ☐ _____

_____

TREATMENT RECOMMENDATIONS

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8

Exposure At:

_____

Treatment Goal: Maxillary Development; Alignment of Permanent Dentition; Retention

Length of Treatment: _____

Cost: _____

Start Date: _____